



Texas Department of Insurance

Division of Workers' Comp

Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

MEMORIAL HERMANN HOSPITAL SYSTEM
3200 SOUTHWEST FREEWAY SUITE 2200
HOUSTON TX 77027

Respondent Name

TEXAS MUTUAL INSURANCE CO

Carrier's Austin Representative Box

Box Number 54

MFDR Tracking Number

M4-12-2369-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The Hospital's records reflect the patient presented to the emergency room on March 16, 2011 for excision and debridement of a right foot burn. On that date, the Hospital contacted Texas Mutual for notification and preauthorization. Texas Mutual stated that preauthorization could not be provided because the patient received treatment through the emergency room. However, the patient was subsequently admitted and Texas Mutual continued to deny preauthorization. The Hospital complied with Rule 134.600(f) and made extraordinary efforts to obtain preauthorization from the carrier only to be denied. Subsequently, the Hospital requested reconsideration of the prior denial which was denied."

Amount in Dispute: \$32,230.50

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Texas Mutual maintains its position the requestor did not have preauthorization for the disputed one day inpatient admission from 3/16/11 and 3/17/11. No payment is due."

Response Submitted by: Texas Mutual Insurance Company, 6210 E. Highway 290, Austin, TX 78723

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 16, 2011 To March 17, 2011	Inpatient Hospital Surgical Services	\$32,230.50	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.
2. 28 Texas Administrative Code §134.600 requires preauthorization for specific treatments and services.
3. 28 Texas Administrative Code §133.2, effective July 27, 2008, 33 TexReg 5701, defines a medical emergency.
4. 28 Texas Administrative Code §134.404 sets out the guidelines for reimbursement of hospital facility fees for inpatient services.
5. 28 Texas Administrative Code §134.404(e) states that: "Except as provided in subsection (h) of this section, regardless of billed amount, reimbursement shall be:
 - (1) the amount for the service that is included in a specific fee schedule set in a contract that complies with the requirements of Labor Code §413.011; or
 - (2) if no contracted fee schedule exists that complies with Labor Code §413.011, the maximum allowable reimbursement (MAR) amount under subsection (f) of this section, including any applicable outlier payment amounts and reimbursement for implantables."
 - (3) If no contracted fee schedule exists that complies with Labor Code §413.011, and an amount cannot be determined by application of the formula to calculate the MAR as outlined in subsection (f) of this section, reimbursement shall be determined in accordance with §134.1 of this title (relating to Medical Reimbursement).
6. 28 Texas Administrative Code §134.404(f) states that "The reimbursement calculation used for establishing the MAR shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Inpatient Prospective Payment System (IPPS) reimbursement formula and factors as published annually in the Federal Register. The following minimal modifications shall be applied.
 - (1) The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by:
 - (A) 143 percent; unless
 - (B) a facility or surgical implant provider requests separate reimbursement in accordance with subsection (g) of this section, in which case the facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 108 percent."
7. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits dated April 29, 2011

- CAC-16 – CLAIM/SERVICE LACKS INFORMATION WHICH IS NEEDED FOR ADJUDICATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE REMITTANCE ADVICE REMARK CODE OR NCPDP REJECT REASON CODE.)
- CAC-197 – PRECERTIFICATION/AUTHORIZATION/NOTIFICATION ABSENT.
- 225 – THE SUBMITTED DOCUMENTATION DOES NOT SUPPORT THE SERVICE BEING BILLED. WE WILL RE-EVALUATE THIS UPON RECEIPT OF CLARIFYING INFORMATION.
- 240 – PREAUTHORIZATION NOT OBTAINED.

Explanation of benefits dated May 17, 2011

- HOSPITAL BILL PROCESSED IN ACCORDANCE WITH RULE 134.404
- CAC-197 – PRECERTIFICATION/AUTHORIZATION/NOTIFICATION ABSENT.
- CAC-97 – THE BENEFIT FOR THIS SERVICE IS INCLUDED IN THE PAYMENT/ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE THAT HAS ALREADY BEEN ADJUDICATED.
- 217 – THE VALUE OF THE PROCEDURE IS INCLUDED IN THE VALUE OF ANOTHER PROCEDURE PERFORMED ON THIS DATE.
- 240 – PREAUTHORIZATION NOT OBTAINED.

Explanation of benefits dated June 14, 2011

- CAC-18 – DUPLICATE CLAIM/SERVICE.
- CAC-197 – PRECERTIFICATION/AUTHORIZATION/NOTIFICATION ABSENT.
- 224 – DUPLICATE CHARGE.
- 240 – PREAUTHORIZATION NOT OBTAINED.

Explanation of benefits dated August 16, 2011

- MEDICAL RECORDS SUPPORTING ADMISSION ON 3/16/11 HAVE NOT BEEN SUBMITTED TO THE CARRIER. DUPLICATE APPEAL.
- CAC-18 – DUPLICATE CLAIM/SERVICE.
- 878 – APPEAL (REQUEST FOR RECONSIDERATION) PREVIOUSLY PROCESSED REFER TO RULE 133.250(II)

Issues

1. Did the disputed inpatient hospital surgical services require preauthorization?
2. Did the disputed inpatient hospital surgical admission meet the definition of a medical emergency?
3. Is the requestor entitled to reimbursement for the disputed services?

Findings

1. Per Texas Labor Code, Section §413.011(b) “the insurance carrier is not liable for those specified treatment and services unless preauthorization is sought by the claimant or health care provider and either obtained from the insurance carrier or order by the commission.” 28 Texas Administrative Code, Section §134.600(c)(1)(B) states, “The carrier is liable for all reasonable and necessary medical costs relating to the health care listed in subsection (p) and (r)...only when the following situations occur...preauthorization of any health health care listed in subsection (p) of this section that was approved prior to providing the health care.” 28 Texas Administrative Code, Section §134.600(p)(1) requires preauthorization of “inpatient hospital admissions, including the principal scheduled procedure(s) and the length of stay.”
2. 28 Texas Administrative Code §134.600 (c)(1)(A), states “The carrier is liable for all reasonable and necessary medical costs relating to the health care: (1) listed in subsection (p) or (q) of this section only when the following situations occur: (A) An emergency, as defined I Chapter 133 of this title (relating to General Medical Provisions).”

28 Texas Administrative Code §133.2 (3) defines “Emergency—Either a medical or mental health emergency as follows: (A) a medical emergency is the sudden onset of a medical condition manifested by acute symptoms of sufficient severity, including sever pain, that the absence of immediate medical attention could reasonably be expected to result in: (i) Placing the patient’s health or bodily functions in serious jeopardy, or (ii) Serious dysfunction of any body organ or part.” Review of the submitted documentation finds that the requestor did not submit documentation to sufficiently support that the inpatient hospital admission was on an emergency basis as defined in 28 Texas Administrative Code §133.2 (3).

3. Therefore, the disputed services required preauthorization per 28 Texas Administrative code §134.600(p)(1). The requestor did not submit documentation to support preauthorization was obtained. Therefore, no reimbursement is recommended.

Conclusion

For the reasons stated above, the division finds that the requestor has not established that reimbursement is due. As a result, the amount ordered is \$0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

Authorized Signature

_____ Signature	_____ Medical Fee Dispute Resolution Officer	05/30/2012 _____ Date
_____ Signature	_____ Medical Fee Dispute Resolution Manager	05/30/2012 _____ Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division rule at 28 Texas Administrative Code §148.3(c).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.